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# Challenges to implementing the WHO Framework Convention on Tobacco Control guidelines on tobacco cessation treatment: A qualitative analysis

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ABSTRACT

**Aim** To identify barriers to implementing the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) Article 14 guidelines on tobacco dependence treatment (TDT). **Design** Cross-sectional survey conducted from December 2014 to July 2015 to assess implementation of Article 14 recommendations. **Setting and participants** Survey respondents (n=127 countries) who completed an open-ended question on the 26-item survey. **Measurements** The open-ended question asked the following: In your opinion, what are the main barriers or challenges to developing further tobacco dependence treatment in your country? We conducted thematic analysis of the responses. **Findings** The most frequently reported barriers included a lack of health care system infrastructure (n=86) (e.g., treatment not integrated into primary care, lack of health care worker training), low political priority (n=66) and lack of funding (n=51). The absence of strategic plans and national guidelines for Article 14 implementation emerged as subthemes of political priority. Also described as barriers were negative provider attitudes towards offering offer TDT (n=11), policymakers' lack of awareness about the effectiveness and affordability of TDT (n=5), public norms supporting tobacco use (n=11), a lack of health care leadership and expertise in the area of TDT (n=6) and a lack of grassroots and multisector networks supporting policy implementation (n=8). The analysis captured patterns of co-occurring themes that linked, for example, low levels of political support with a lack of funding necessary to develop health care infrastructure and capacity to implement Article 14. **Conclusion** Important barriers to implementing the Framework Convention on Tobacco Control Article 14 guidelines include lack of a healthcare system infrastructure, low political priority and lack of funding.

Key Words: Tobacco Dependence, Cessation Treatment, Implementation, Global, FCTC, Article 14

INTRODUCTION

The World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC) is an evidence-based treaty aimed at reducing the global burden of tobacco use [1]. Article 14 states that "each Party shall take effective measures to promote cessation and adequate treatment for tobacco dependence." To facilitate adoption of this provision, the FCTC developed guidelines for the implementation of Article 14, which set out the core infrastructure and more detailed strategies to support national tobacco cessation efforts [2].

There is strong evidence for a range of effective and affordable tobacco cessation interventions at both the clinical and population level [3]. Yet, progress in implementing

Article 14 has been slow, particularly in low and middle-income countries (LMICs) [4-6]. A 2015 survey of contacts in 142 countries found that fewer than half of Parties to the FCTC have implemented the recommendations of Article 14 and its guidelines [4]. For most measures, treatment provision was more likely to be available in high income countries [HICs]. The 2019 WHO report on FCTC implementation (i.e., MPOWER report), also noted that "cessation policies are the least implemented of all WHO FCTC demand reduction measures" [7].

Numerous studies have described barriers to implementing tobacco dependence treatment (TDT) guidelines in health care settings, but most studies have taken place in high-income countries (HICs) [8-10]. Moreover, we are not aware of any studies that have examined, at a national level, barriers to implementing measures articulated in Article 14, which would make treatment more widely available. To begin to fill this gap, this paper presents findings from responses to an open-ended question in the 2015 survey, described above, that asked participants to offer their perspectives on barriers and/or challenges associated with implementing Article 14.

## METHODS

The survey methods are described in detail in a previous publication [4]. Briefly, researchers surveyed contacts in 172 countries, representing 169 of the 180 FCTC Parties at the time of the survey. The European Union as a non-state Party was excluded, as were 10 FCTC Parties where contacts were not found.

Contacts were identified from previous surveys and recommendations from various stakeholders, such as the WHO regional offices and the Framework Convention Alliance, and included tobacco treatment specialists and government and non-government representatives involved in tobacco control in their countries. The survey included 26 items and was administered either through an online link or by completing a word attachment sent via email, and was offered in English, French, Spanish and Russian. One open-ended question asked participants the following question: *"In your opinion, what are the main barriers or challenges to developing further tobacco dependence treatment in your country*?"

We conducted a thematic content analysis of responses to this question [11]. Through an iterative process, two study team members independently reviewed the open-ended survey responses, identified and defined salient themes and subthemes and captured patterns of co-occurring themes within individual responses to assess relationships between themes [12]. The larger team reviewed the initial coding schema, allowing for some codes to be redefined and/or collapsed until consensus was achieved. Once the codebook was finalized a team member independently conducted a final coding of the quotes. For each quote, we identify the country income-level of the respondent based on World Bank

classifications: Low-Income (LIC) Lower-Middle Income (LMIC), Upper-Middle Income (UMIC) and HIC.



## RESULTS

Contacts from 142 countries completed the survey and 138 contacts responded to the survey item analyzed for this paper. We excluded 11 responses that did not address the question asked (e.g., no barriers reported). Therefore, the final analysis included responses from 127 countries (12 LIC, 33 LMIC, 36 UMIC, 44 HIC, and 2 with no income classification).

### Barriers

Table 1 shows the major themes, the number of times a theme and subtheme were identified in the analysis and illustrative quotes. Figure 1 illustrates the distribution of themes by country income level.

The most frequently reported barriers were gaps in the necessary health care system infrastructure to deliver tobacco dependence treatment (n=86) and political priorities that were not aligned with Article 14 goals (n=66). Both barriers were more commonly reported by UMIC and LIC/LMIC than HICs (Figure 1). One respondent described the government's priority as "*still focused on infectious and maternal and child [health] rather than non-communicable diseases,*" *(LMIC),* and another noted that public officials do not view this [tobacco cessation] as *"an important issue." (UMIC)* The absence of policies, strategic plans and/or national guidelines for TDT for Article 14 implementation emerged as subthemes of political priority and further illustrated how low levels of government support impede progress toward achieving Article 14 goals. Although national guidelines alone do not ensure implementation, they provide an important roadmap for developing evidence-based population and health system-level TDT programs.

Subthemes that emerged under health care infrastructure described gaps in workforce training opportunities that are needed to build capacity to deliver TDT and system changes to facilitate integration of TDT into routine primary care. For example, one participant noted that "*Primary care facilities are not ready to deliver brief tobacco interventions." (UMIC)*

A lack of funding was also a commonly reported barrier to implementing Article 14 (n=51). Funding gaps were reported across all income levels (Figure 1) suggesting that larger healthcare budgets may not guarantee all HICs will allocate those resources for TDT.

Persistent population norms and beliefs that support smoking were also described as slowing progress. As one respondent noted, "*it is not seen as a major public health issue by*

*the populace*" *(UMIC).* In addition, providers' negative attitudes towards treating tobacco dependence was perceived as a barrier, particularly among HICs. Participants suggested several reasons for this finding, including a lack of knowledge, compensation and time. Although not as frequently mentioned, several participants acknowledged the value of creating networks or coalitions that facilitate collaboration between researchers, policymakers, civil society and the health care community to advocate for increasing access to TDT.

Relationship between barriers

Figure 2 represents a preliminary framework for understanding the multilevel factors that influence implementation. Based on participant's responses, arrows depict how these factors may interact to impede FCTC Parties from fully implementing Article 14. For example, one participant made a link between political priorities and low levels of funding: *"there is a lack of [political] commitment and dedicated resources*" *(LMIC)*. Another specifically linked a lack of funding to gaps in the infrastructure needed to implement Article 14: "*funding is the main barrier [to implementation] as it restricts training of health care professionals, engagement of resource personnel implementation of brief cessation therapy at the primary health care level and availability of NRT."(UMIC)* Others suggested that the government needed to create a funding source to facilitate action: "*smoking cessation is not a priority because the means are insufficient" (LIC)*. Additionally, physicians' view of TDT as a "low priority" was described as related to a gap in infrastructure (e.g., lack of training) and the lack of national treatment guidelines (i.e., political priority).

Participants suggested that leadership among health care and networks to advocate for treatment are needed to create political pressure to allocate funding to fully implement national guidelines for TDT. Similarly, smokers' lack of awareness about treatment options and effectiveness may contribute to "*low demand*" *(LMIC)* for services and thus less political pressure to offer services. Finally, figure 2 illustrates how external factors that influence policy like population norms that still support tobacco use, policymakers' lack of knowledge about treatment affordability and tobacco industry interference can all influence political priorities and subsequently resource allocation for TDT [13,14]. As the analysis was not pre-registered on a publicly available platform the results should be considered exploratory.

DISCUSSION

To our knowledge, this is the largest qualitative assessment of barriers and challenges to implementing TDT as specified in Article 14 and its guidelines. Our findings suggest that the primary reasons for the lack of progress are the low priority that governments/public health leadership place on Article 14 and the resulting lack of funding and infrastructure needed to ensure that evidence-based treatment is widely available. These data are consistent with the

quantitative findings from the same 2015 survey in which only 25% of survey participants reported that their country had a clear budget for treatment, only 40% reported having official national treatment guidelines and most reported a lack of other infrastructure and cessation support systems [4]. The qualitative findings, derived from the open-ended question, fill gaps in this literature by providing additional insight into why there has not been greater progress towards implementing Article 14 guidelines. In addition, these data further elucidate the complexity of Article 14 policy and program implementation by highlighting how these barriers are interrelated at many levels.

Our findings are consistent with prior literature on shaping population health policy and with the WHO's 2018 progress report on *overall* FCTC implementation [15,16]. For example, the WHO-reported barriers included "financial resources that do not match needs" even in HICs, interference by the tobacco industry and a lack of political priority [15]. This study adds to the WHO report by identifying implementation challenges specifically related to Article 14, thus offering a path to developing solutions to overcome the challenges described by participants across all income levels. For example, many policymakers remain concerned about the cost of treatment. However, several core policy and system changes need not be expensive, for example, mandating screening all patients for tobacco use and recording tobacco use in medical notes, currently only done in 30% of countries [3, 4]. There are also examples of feasible effective models for leveraging existing primary and community-based care to facilitate access to cessation treatment [2, 7].

Disseminating evidence to key decision makers is critically important, including the evidence that integrating cessation measures into an overall tobacco control plan can increase program impact due to the synergistic effect of FCTC components [7]. However, translating that evidence into public health policy and clinical practice is challenging, regardless of a country's income level. Accelerating evidence translation will require an investment in strategies that that have the potential to address these and other barriers [7, 16-19]. This includes investments in ongoing stakeholder engagement, capacity building, and technical assistance to support the development of national tobacco cessation policies and guidelines that are integrated with national tobacco control plans, and support for designing, implementing and scaling affordable treatment models that are aligned with context-specific resources and infrastructure [20]. Another aim of technical assistance would be to help countries identify sustainable funding sources (e.g., earmarked tobacco taxes for treatment) and offer guidance on how to prioritize funding given limited resources and competing priorities [18].

Finally, there is a need to further explore the reasons why TDT remains a low political priority globally. Our study provides some perspective on this question, and additional answers will come, in part, through activities suggested above. However, comparative policy

analyses, that are guided by dissemination and implementation frameworks, are needed to help explain how, why, and under what circumstances (e.g., varying political systems) Article 14 has been unsuccessfully vs. successfully implemented and sustained [21]. This type of research would shed light on the structures, systems and processes that lead to implementation of population-based and health care system approaches to tobacco cessation.

The study has several limitations. There was the potential for response bias and subjectivity in the responses. Responses were from a range of professionals, both inside and outside government, and represent only their view of their country's challenges. In addition, we did not specify how to report barriers (e.g., top three, most important). Therefore, there may be barriers that were not reported and others that were given more weight than is warranted. Additional limitations related to the study design are described in a previous paper [4].

With the growing burden of tobacco-related non-communicable diseases, there is a strong argument for investing in the infrastructure for delivering cessation services [22]. The framework we propose offers Parties to the FCTC a guide for evaluating the multilevel factors that influence implementation of Article 14 in their specific political, social and cultural context, and can inform the design of strategies to advance policy goals, increase access to evidence-based TDT and improve health outcomes globally.

Author contributions

MR conceived and originated this survey and first drafted the original survey questionnaire. AM, RM, KN and MR contributed to the design of the survey questionnaire and study, and KN collected, collated and analyzed the data. DS, MR and AM conceived the purpose of the study, DS and CK conducted data analysis and drafted the manuscript; MR, AM, RM, KN and SS contributed to the editing of the paper**.**

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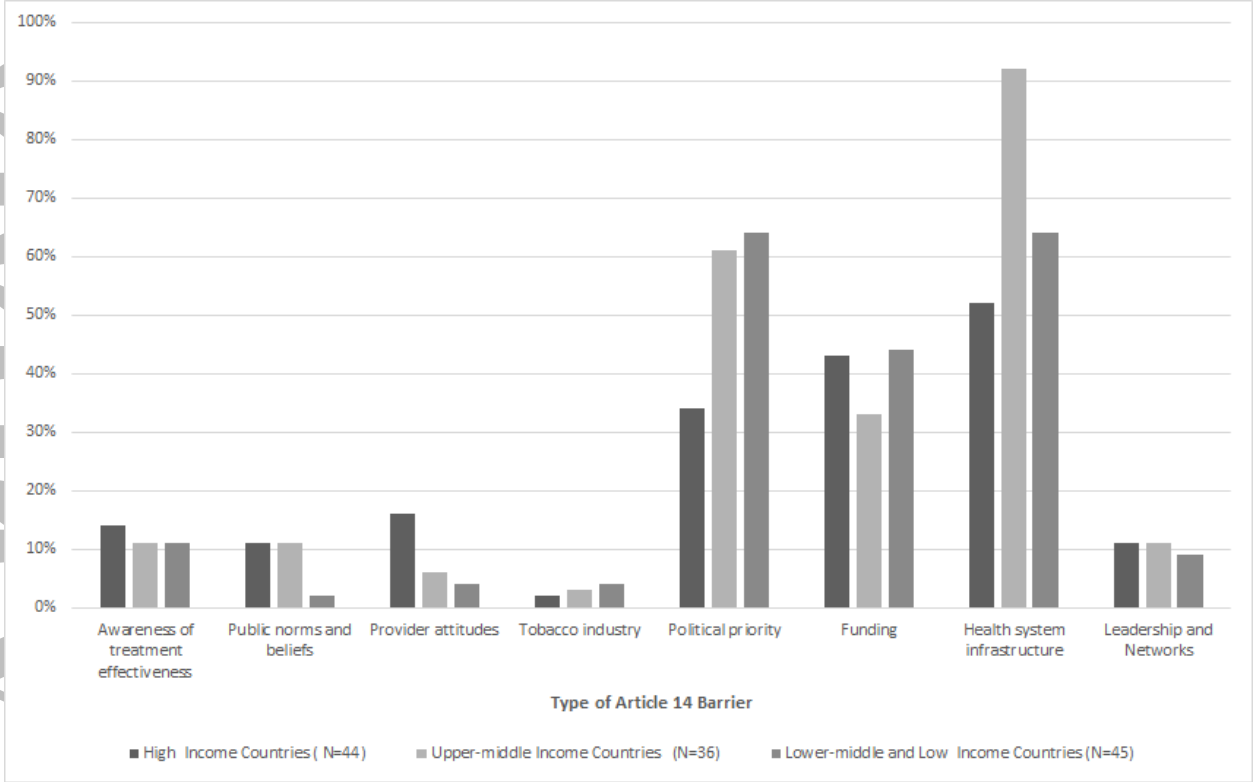
Figure 1. Percent reported barriers to implementing Article 14 by country income level*




*A higher percentage reflects the degree to which particpants within a country income level responded that the theme was a barrier

Figure 2. Framework for understanding barriers of Article 14 implementation

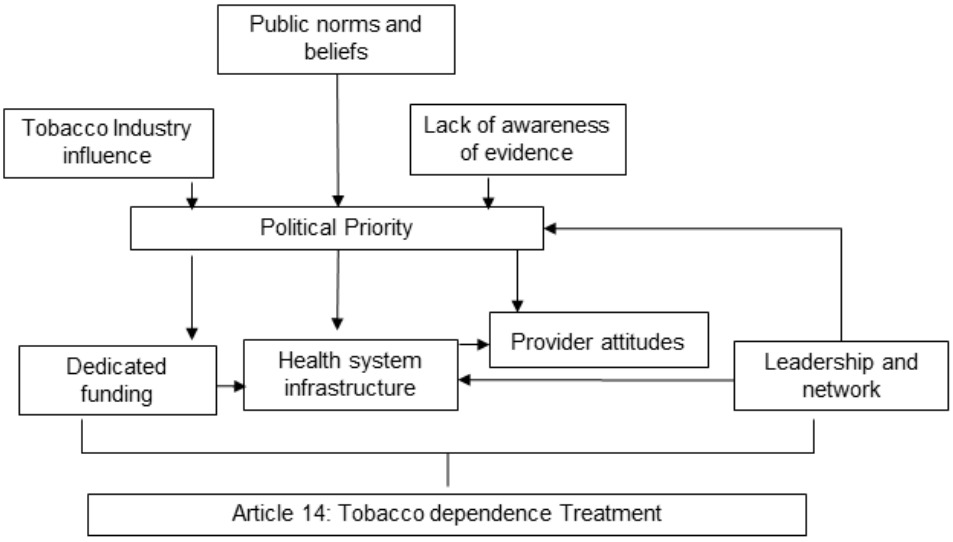


**Table 1. Participants' assessment of barriers to implementing Article 14**

*N=in each row is the number of total quotes under that theme.

| Barriers | Illustrative quotes | N* |
|---|---|---|
| **Health system infrastructure** | | **86** |
| Lack of treatment infrastructure, services and coverage | "No adequate dedicated centers for cessation" (LMIC)<br>"The challenge is adequate treatment of health promotion and disease prevention and setting foundations of health system as it is expected" (UMIC)<br>"Lack of integration of brief advice in PHC" (UMIC)<br>"Health insurance companies do not pay for tobacco dependence treatment (UMIC) | 39 |
| Cost and availability of pharmacotherapy | "Medication is not easily affordable and recently not available … pharmaceutical companies no longer marketing it due to limited sales" (UMIC)<br>"Funding for meds" (HIC) | 22 |
| Gaps in workforce capacity | "Limited human resources to provide training for healthcare providers on tobacco dependence and brief intervention" (HIC)<br>"Lack of skilled human resources to support smokers for smoking cessation" (LIC) | 25 |
| **Political priority** | | **66** |
| Political will | "Lack of will from the government to push treatment" (HIC) | 32 |
| Lack of strategic plan | "Lack of strategic document for tobacco dependence" (LIC)<br>"No national tobacco cessation strategy...have been developed" (HIC)<br>"Failure to develop national guidelines for integral care for treatment of dependence"(UMIC) | 14 |
| Lack of policies to support treatment | "Cessation has not been addressed at the policy-level" (UMIC)<br>"No clear national governmental policy regarding tobacco dependence treatment" (HIC) | 20 |
| **Funding** | | **51** |

| | | |
|---|---|---|
| General statements about lack of funding for treatment infrastructure and efforts to raise public awareness | "Government does not allocate budget to stimulate throughput in services, or increase awareness of services" (HIC)<br>"[Lack of] funding for Article 14 at the National/Governmental level" (LMIC)<br>"Not enough funding for prevention, research, and addiction centers" (HIC) | |
| **Awareness of treatment effectiveness** | | **16** |
| Lack of awareness of cost-effectiveness among policymakers | "Need for a costing study to enable the government to make an evidence-based decision to support (financially) tobacco cessation services" (UMIC)<br>"Cost effectiveness is underrated" (HIC) | 5 |
| Public lack of awareness | "Lack of information to the public about benefits of treating dependence" (UMIC)<br>"Information and awareness of the success and benefit of NRT should be available" (LMIC)<br>"Lack of public information which does not induce demand" (LMIC) | 11 |
| **Public norms and beliefs** | | **11** |
| Public opinion about tobacco use | "Tobacco is still culturally accepted" (UMIC)<br>"We are sympathetic towards those who smoke" (No income-level rating by World Bank)<br>"It is not seen as a major public health issue by the populace" (UMIC) | |
| **Provider attitudes** | | **11** |
| Health care worker's attitudes toward role and treatment | "Needs to be a shift in attitude in patient care so that healthcare workers consider it to be an obligation to advise patients on the health risks associated with tobacco use and counsel patients about quitting" (HIC)<br>"Physicians are not sufficiently motivated to provide preventive service" (HIC)<br>"Lack of motivation of health workers and pharmacists" (LMIC) | |

| | | |
|---|---|---|
| **Leadership and Networks** | | **14** |
| Leadership | “No leader, an expert on tobacco dependence treatment” (UMIC)<br>“Lack of tobacco control leaders trained in the treatment of tobacco dependence” (LMIC) | 8 |
| Networks | “[Need] Greater involvement of relevant sectors in smoking cessation process” (UMIC) | 6 |
| **Tobacco industry** | | **4** |
| Tobacco industry interference | “Tobacco Industry interference” (LMIC)<br>“Strong tobacco lobby” (UMIC) | |